



The Hampden Hippocrat

A Bulletin for the Hampden District of the Massachusetts Medical Society

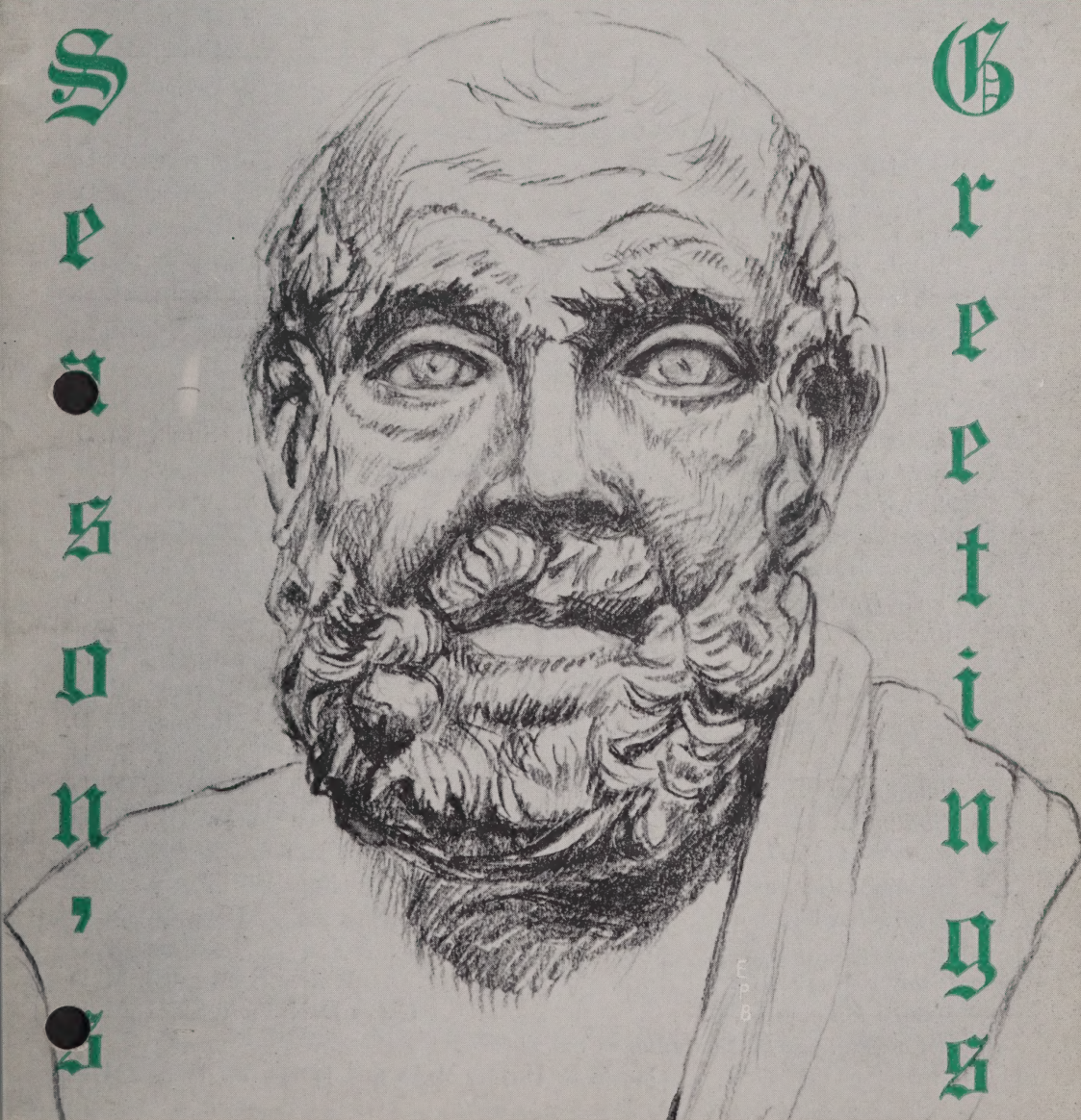
VOLUME XXII

DECEMBER, 1966

NO. 10

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RELIGION and ETHICS IN MEDICINE

Hampden District Medical Society

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The Hampden Hippocrat

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Hippocrates

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EDITORIALS

MEDICINE AND RELIGION COOPERATION AND CHANGE

GARRY deN. HOUGH, III, M. D.

Chairman, Medico-Religious Committee

It has become trite to call our present environment a time of change. After all, change is somewhat more inevitable than either death or taxes. But a cursory glance at the rate of current social change shows that it has permeated two of our most conservative institutions, medicine and religion. Two random, but possibly related, examples could be the report of the Citizen's Committee on Medical Education and doing the "frug" in Boston's Old South Church. Both professions will have to choose whether to be the architects of change or merely the observers. The recent governmental intrusion into the practice of medicine indicates how physicians are being relegated to the observer role.

My predecessors on the Medico-Religious Committee of our Society have established an ecumenical discussion group capable of sincere intercommunication. Our present efforts are directed toward using this communication to improve patient care. This December issue of the "Hippocrat", traditionally devoted to religious and ethical aspects of medicine, contains two articles from this Committee. Each views the patient-doctor-clergy relationship from an apex of the triangle in the hope of improving objectivity.

It is my hope that this type of cooperative cross-examination may permit some of the social expertise of the clergy to be applied to the changes facing medical practice. Most present day physicians are so thoroughly imbued with the doctrine of specific etiology and specific therapy that they are emotionally unable to consider illness from any other point of view. The philosophy of "one disease - one cause" has permitted the fantastic medical progress of the past 150 years. But have we followed this line of reasoning to the point of diminishing returns? Could the public dissatisfaction with present medical care reflect limitations which we have imposed upon ourselves? If so, a re-evaluation of the function of the physician by professionals with a different training and a new vocabulary may contain some useful contributions. For example the suggestion that "the sick individual is often merely the shock organ of the sick society", William Nute, Jr., M.D. "Healing", 1966.

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MEDICAL ETIQUETTE

Medical etiquette may seem unfamiliar to some physicians, particularly the younger, because the suggested guidelines for this aspect of our professional conduct were not labeled as such when the A.M.A.'s "Principles of Medical Ethics" were revised in 1957. The latter succinctly express the fundamental ethical concepts embodied in the cumbersome earlier document which had served for 110 years. Following sections 1, 4, 5, and 8 of the "Principles" as published in the A.M.A.'s "Judicial Council Opinions and Reports — 1966", are the opinions pertaining to medical etiquette and are hereby highly recommended for study.

Virtually all physicians know what is right or wrong, and all are naturally considerate of their patients' and colleagues' feelings. However, some seem to have some difficulty in applying the "Principles" to specific prob-

...m areas. Answers based on the following three criteria can and almost invariably do yield the right answer when applied to any problem of medical etiquette. First, is the intent of the act or practice for the benefit of the patient, the public, the profession or the physician? If it is primarily for the physician's own benefit, then it is probably unethical. Secondly, is it in keeping with local customs and community ideals? Thirdly and lastly, is it in keeping with the "golden rule"? The physician should always ask himself what he would expect if the position were reversed.

Proper medical etiquette or manners can open the way for mutual understanding, sharing of knowledge, and fellowship which are traditional with our profession. The physician who does not enjoy the good will of his colleagues can expect a lonesome and unhappy professional life. Furthermore, if we, as physicians, would consider the dignity and heritage of our profession, place service above self, and let empathy dictate our actions, there would be no need for rules of medical etiquette.

Ayres



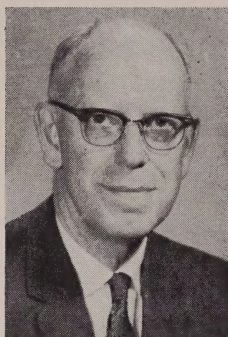
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President's Page



THE GOLDEN RULE

The current issue of the "Hippocrat" deals with ethics. One definition of ethics is "the principles of conduct governing an individual or a group." In this, the Christmas season, it is easy to elaborate on such a definition and paraphrase it into the "Golden Rule."

If we all did unto others as we would have them do unto us, there would be no need for committees on ethics and discipline. Unfortunately, we all are human and subject to human frailties. Most of the breaches in ethics, I am convinced, are due to thoughtlessness rather than malicious intent. With this in mind, let us all start the New Year with a feeling of kindness, thoughtfulness, and concern for the other fellow — be he patient or colleague.

A Merry Christmas and a Happy New Year to you all.

DONALD R. HAYES, M.D.

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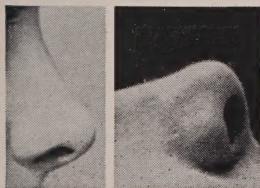
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WHAT MY PARISHIONER NEEDS FROM HIS PHYSICIAN

By REV. LANGFORD BALDWIN

Member, Medico-Religious Committee

Illness is not all bad, for it brings growth to many patients. It is a time when searching questions about life are often asked. As these questions are faced, and conclusions or decisions based on honest data are reached by the patient himself — not imposed on him by a clergyman or a friend or a physician in whom he puts his trust — he moves toward total health.

Are doctors aware of the extent to which patients put their trust in them? What the physician says is often prime data from which religious conclusions are drawn. When a woman loses her baby in the third to six month of pregnancy, she may be given by her doctor the medical (not religious) opinion that "it is a good thing the pregnancy ended because the child was malformed." The stress on deformity by the doctor whom the patient trusts so implicitly could be a major factor in leading her to think for a long time afterward of the "thing" that she bore, seeing the pregnancy as a sad waste and the abortion as a "punishment" that, perhaps, she deserved. There are healthier conclusions than this that could be drawn, to which it is a clergyman's task gently to point. The more physicians and clergy could work together to produce healthy attitudes towards life's tragedy, the bet-

ter it would be for those we serve.

Are doctors aware of the extent to which they are asked to make ethical decisions for their patients? "What must it be, doctor, home care or institutional care?" The decision must be based on much more information than the physician usually has about the patient himself, including his home situation and religious beliefs. Doctors and clergy could well work together to help the family reach the decision, guarding always, however, against taking the decision from the family where it belongs.

More frequent consultation between our two professions would not only help us to understand the patient better than we do but would also help the patient to understand better his own changing moods. Depression, for example, will often have physical, not spiritual causes, but laymen (and this includes clergymen here) do not always know at what stages of an illness depression is likely to occur. Doctors could help clergy to help relieve their parishioners' anxiety on this point. On the other hand, doctors may better understand their patients if they know something of the religious problems they are wrestling with.

A doctor might do well to make it a standard practice to ask his patients

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who face surgery or a serious illness if they would like him to discuss their case with their clergyman as well as with members of the family. This need not carry a suggestion of last rites if the doctor sees a clergyman's role as larger than a Sunday preacher and death bed consoler. No doubt a great many will answer "no", indicating no relationship at all with a clergyman or, in some cases, a relationship that is lacking in adequate trust. But when the answer is "yes", as it will sometimes be, this will usually indicate a trustful, on-going relationship that could contribute to the attainment of total health. If a "yes" answer is given, the physician should listen for indications that the patient's relationship with his family is a distrustful one, for in some cases he could be saying that he prefers to share his anxieties not with his family but with his clergyman. And surely a "yes" answer could be the patient's way of saying that he sees healing in a wider perspective than the healing of the body alone.

I hope these words may suggest to some doctors, who may have stereotyped clergymen as praying, meddling, "do-gooders", that it might serve their patients' interests if they

were to develop an inter-professional relationship with some clergymen. Of course professional competence varies among clergymen as among physicians, and just as there are some doctors who do not merit much trust from their profession, so there will be clergymen whom physicians will learn to distrust. But should you not give a fellow professional the benefit of the doubt to begin with, and seek him out, or enable him to seek you out, for exchange of helpful thoughts in general or with regard to a particular patient? I myself would be delighted if some day I were to get a phone call from a physician saying, "I would like to meet you. Could we, perhaps, have lunch together at the hospital?"

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People will listen a great deal more patiently when you explain your mistakes than when you explain your successes. —Walter D. Nesbit

—Walter D. Nesbit

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WHAT MY PATIENT NEEDS FROM HIS CLERGYMAN

by

LEROY J. KENDREW, M.D.

Member, Medico-Religious Committee

As physicians in training we were taught to treat our patients as a "whole" individual — to consider each person as an integrated unit of body, mind and spirit. Second only to this advice was the admonition to hear our patients out, for in so doing, the diagnosis would eventually be made for us.

Have we, individually or as a group, fallen into the expedience of neglecting one or both of these precepts? Has over-specialization or the excuse of time limitation deterred us from adhering to these basic rules?

If we will listen with discerning attention to the present criticism of our profession, the public's answer is clear. Our patients feel that we are neglecting to see them as "whole" individuals. They feel that, as physicians, we have allowed specialization to result in fragmentary therapy. We stand accused of having been led down the path of depersonalization by the so called "progress" of the computer age. Our patients trusted us to resist this modern trend, and they feel we have let them down.

Are their criticisms justified? Are we responsible in whole or in part for our changing professional "image"?

Furthermore, do we as physicians feel capable of understanding and treating the "unity" of the integrated man, or do we need further help?

Only individually can we answer these questions. If answered affirmatively, only individually can we supply the solution.

Dr. Paul Tournier, the renowned Swiss psychiatrist in "The Healing of Persons" states: "Man — body, mind and spirit — is a unity. The life he lives in his body corresponds with the life he lives in his mind and the life he lives in his spirit. Everyone understands what is meant by body, but I must make clear the distinction between mind and spirit. Mind, psyche, is the domain of psychology—the will, intelligence, feeling, moral sense, etc. The spirit expresses itself through all these and also through the body, but it is neither the mind or the body. It is concerned with the personal relationship of man with God, and fashions the mind and the body in accordance with that relationship."

He further states: "The physical problem of a person's life corresponds to his psychic problems, and both these kinds of problems correspond to spirit-

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ual problems. One cannot tend the body without tending the mind and the spirit. There is no physical reform possible without moral reform. And there is no moral reform without spiritual renewal."

In light of this, let us, therefore, reassess our individual diagnostic and therapeutic methods. If we have strayed from the precepts handed down by our earliest teachers and have been lured into understandable yet therapeutically defeating pitfalls, we must return to the recognition and treatment of our fellow man as a unique integrated unity. We must listen and observe what dysfunction exists between the body, mind, and the spirit. As physicians with knowledge of what therapy must be employed to restore a healthy body and mind, we must

bend all efforts to affect such an integration. But do we need help to understand and to restore the further integration with the spirit? I can only answer this as an individual physician. I need the assistance of my patient's spiritual advisor, not only because of his intimate relationship with my patient, but because I need his experience and training in restoring my patient's spirit to its proper integration with body and mind.

To answer the question "What does my patient need from his clergyman?", I would have to answer, that he needs a closer, cooperative relationship of his clergyman with his physician, for only by such a relationship can the ultimate approach to complete therapy be achieved.

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COMING EVENTS

HDMS MEETING, FEBRUARY 7, 1967

HDMS EXECUTIVE COMMITTEES, DECEMBER 20 and JANUARY 17

ACADEMY OF MEDICINE, JANUARY 10

MMS COUNCIL MEETING, FEBRUARY 8

NATIONAL CONGRESS OF THE SOCIO-ECONOMICS OF

HEALTH CARE, CHICAGO, JANUARY 22 and 23

MMS ANNUAL MEETING, BOSTON, MAY 16, 17 and 18

AMA ANNUAL MEETING, ATLANTIC CITY, JUNE 18-22

EXECUTIVE COMMITTEE MEETING (Highlights)

The Executive Committee met on November 15, 1966, at the Society's conference room. Present were: Drs. Hayes, Griffin, Nero, Mozden, Wiedman, Moore, Stoler, Beauchamp, and Mrs. Purdy.

Dr. Hayes, President, called the meeting to order at 8:10 P.M.

The minutes of the October meeting were read by Dr. Griffin and approved as read.

Committee Reports

The Members' Insurance Committee gave a very excellent report with recommendations. (See page 20)

The Medico-Religious Committee presented an informational report which was accepted.

A short report of the Diabetes Detection Committee was given. This meeting was held during Diabetes Detection Week.

A report of the Public Health Committee was read. This had to do with a recent meeting held with Dr. Walter English of the Springfield Department of Education. Dr. Walter Pacosa spoke on behalf of the interested pediatricians in the area. A future meeting of the Public Health Committee and the interested pediatricians will be held soon to discuss problems in this area.

New Business

Because the Annual Meeting had been booked on the first day of Passover, April 25, 1967, it was voted to change the meeting to Monday, April 24th.

The date of the Executive Committee was also changed from April 18 to April 17.

The speaker for the February District meeting will be Mr. L. T. Reed, Assistant Executive Director of the Massachusetts Medical Service in Boston. The meeting was adjourned at 10 P.M.

The committee met as the Grievance Committee.

Four grievances were heard and appropriate letters will be written to the patients and physicians involved.

The meeting adjourned at 11 P.M.

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DECEMBER MEETING

HIGHLIGHTS

(Dec. 6, 1966)

The December meeting was held at the Kimball Towers, Springfield, with President Hayes calling the meeting to order at 6:35 p.m. Attendance: 190; reservations: 204.

Minutes of the Sept. 27 meeting were read and accepted. Dr. Hayes thereupon called for committee chairmen reports.

Dr. Tillman reported for the Insurance Committee. He announced that a new program of disability income and major medical expense insurance has been adopted and is to be administered by the Lester M. Burdick, Inc. for the Commercial Insurance, Inc. of New Jersey. This program will replace the previous insurance program underwritten by Hartford Accident and Indemnity, Inc. A charter member enrollment period is in progress and will continue until January 15, 1967. Members were asked not to pay bills sent out by Lessere-Wertheim, Inc. since this program is to be discontinued.

Dr. Susat, reporting for the Legislative Committee, recommended that a request be made to the M.M.S. to refrain from having physicians serve

on the Mass. Board of Registration of Chiropractors. This recommendation had been made at a previous meeting and had been referred to the Executive Committee. The Executive Committee disapproved the motion explaining that it was to the Society's advantage to have physician members on this Board. It was, moreover, brought out that Gov. Volpe had already appointed two physicians to the Board. Furthermore, it was pointed out that if physicians are not appointed to the Board, their places would be filled by chiropractors. The motion was discussed by the membership with Dr. Buck, Secretary of the M.M.S., reporting for the State Society. The motion was defeated by the membership.

Dr. Hayes indicated plans to form a Blood Bank Committee.

The meeting recessed for a social hour which was followed by the dinner

The meeting was resumed at 8:45 p.m. with Dr. Hayes introducing the guest speaker, Dr. F. J. J. Blasingame, Executive Vice President of the A.M.A. who talked on "Your A.M.A. and You." Following his very interesting presentation, a question and answer period ensued.

There being no further business, the meeting adjourned at 10:00 p.m.

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HISTORY OF MEDICAL ETHICS

The best, and probably only, way of tracing the history of medical ethics is to review the various medical oaths, codes, and declarations that have come down to us through the ages. Since the most popular and most enduring of all oaths is that of Hippocrates, we may, for convenience, divide these documents into three categories in accordance with the era in which they were issued:

1. Ancient, or Pre-Hippocratic, Era.
2. Hippocratic Era.
3. Modern, or Post-Hippocratic, Era.

Ancient Era

Little is known about medical ethics in the earliest times of human history. It would seem, however, that the primitive leader, the "shammon", who was mayor, policeman, priest and physician all rolled into one, had only his conscience to guide him. The functions of the "medicine man", who subsequently appeared on the scene, were limited to those of physician and priest — a combination that persisted for many years. The very idea of such a combination suggests that some awareness of right and wrong in medical morality existed even in primitive times.

An excellent example of the physician-priest combination is the first re-

corded "doctor" in history, the Egyptian physician Imhotep, who lived around 2900 B.C. We have no knowledge of a medical oath linked with this great physician who many years later was deified in the Egyptian religion.

If we exclude personal vows and the oaths of service sworn by physicians when appointed to the courts of the Pharaohs and kings, we find that the earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the "Code of Hammurabi", was indeed a code of conduct, setting forth in considerable detail for that era the nature of conduct demanded of a physician. Next we encounter the "Oath of the Hindu Physician", which dates to around 1500 B.C. This oath emphasizes the ethics of the physician toward his patients but makes no mention of his obligations to his colleagues. Women patients, it stresses, cannot be treated "except their men be present." It also bars divulging a patient's confidences.

An indication of another medical oath is contained in the "Book of the Law of the Persians" (1000 B.C.). This describes the examination and certification of physicians. The successful candidates apparently had to take an oath, a copy of which was

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Hippocratic Era

Hippocrates, the "Father of Medicine" (and incidentally the "patron saint" of our bulletin), was born around 460 B.C. One of the many things for which he is remembered is his famous "Oath", which even today is taken at some universities by graduating medical students. In the Middle Ages, the "Oath of Hippocrates" enjoyed its greatest popularity, but of late, this has fallen off to a considerable degree. A 1965 survey showed that of 84 American schools only 21 used the "Hippocratic Oath" (Pagan version, 7; modernized, 14), while 41 schools used other oaths and 22 used no oaths at all. Both the Christian and the Jewish versions of the "Hippocratic Oath" understandably omit the invocation to the pagan gods of Apollo, Asclepius, etc. The "Oath" begins with a covenant dealing with the medical apprentice's duties toward his teacher and the teacher's family;

however, in the opinion of many, it does not speak enough of the physician's obligations to his patient, the public and his colleagues.

Modern, or Post-Hippocratic, Era

Following Hippocrates we find that a number of other oaths were formulated and employed. The most notable of these are the "Oath and Prayer of Maimonedes", the great Jewish physician and philosopher of the 12th century, and the "Private Oath of Amatus Lusitanus", the 16th century Portuguese physician.

The first modern code of medical ethics was compiled in 1803 by the English physician Thomas Percival for use at the Manchester Infirmary. It is from this code that the A.M.A. derived its own "Code of Ethics" shortly after its organization in 1847. Since then several revisions and modifications of the original code have taken place, culminating in the current "Principles of Medical Ethics"

(More on Page 18)

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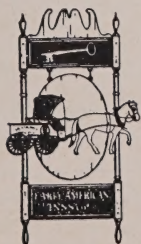
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of the A.M.A. The "Principles" consist of 10 Sections, the purpose of which is enunciated in the Preamble:

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

Although all of the 10 sections would fill not more than two printed pages, their interpretation and elaboration by the A.M.A.'s Judicial Council in its 1965 "Report" covered more than 60 printed pages. (A copy of this is available at A.M.A. headquarters). To meet local or geographic needs many state medical societies have supplemented the A.M.A.'s "Principles of Medical Ethics" with codes of their own. Thus, our state society expects its membership to abide not only by the A.M.A. "Principles" but also by its own "Code of Ethics" and its "Publicity Guide."

For almost a century no new ethical codes of international, or even national, significance came to light. This is interesting, but even more interesting is the fact that in the last 20 years no less than 3 very important documents dealing with medical ethics have appeared on the medical horizon:

(1) "THE NUREMBERG CODE OF ETHICS IN MEDI-

CAL RESEARCH" was formulated after World War II to guide the Allied Military Tribunal in the prosecution of Nazi physicians accused of brutal experiments on political prisoners.

(2) "THE DECLARATION OF GENEVA" was adopted in 1948 at Geneva by the World Medical Association as an updated version of "The Hippocratic Oath." Eleven American medical schools use "The Declaration of Geneva" as a professional oath according to the 1965 survey.

(3) "THE HELSINKI DECLARATION" was adopted in 1964 by the World Medical Association as a deep desire to establish guidelines for research and to help protect patients and society from any practice, in the name of medicine, not wholly acceptable morally. Clinical research should be governed by four basic principles:

(a) *ETHICS*—Human experimentation must conform to the moral and scientific principles that justify medical research. It should be based on laboratory and animal experiments or other scientifically established facts.

(b) *QUALIFICATIONS*—Clinical tests should be conducted only by scientifically qualified persons and under the supervision of a qualified physician.

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(c) *PREPARATIONS* —

Every project should be preceded by careful assessment of inherent risks weighed against foreseeable benefits.

(d) *PRECAUTIONS* —

The physician must exercise special caution to protect the personality of the individual from alteration by drugs or experimented procedures.

Conclusion

The history of medical ethics covers a span of some 45 centuries. The keen interest of our profession in the enhancement of medical morality is well demonstrated in the numerous oaths, codes, and declarations formulated during these centuries. The multiplicity of these documents, however, would tend to indicate that the perfect code of ethics is yet to be discovered. Times do change, creating new problems and raising new questions. In this generation of race murders, nuclear annihilation, racial violence, overpopulation, artificial insemination, organ transplan-

tation and other disquieting developments, our ethical attitudes may well have to be re-evaluated from time to time. The A.M.A. has found it necessary to revise its "Code" several times since the original was adopted in 1847.

Our chief hope lies in giving clear expression to basic concepts and principles, and this the A.M.A.'s Judicial Council is constantly striving to accomplish.

Millman

Whenever you see persecution, there is more than a probability that truth is on the persecuted side. —Hugh Latimer

Because half a dozen grasshoppers under a fern make the field ring with their din — do not imagine that those who make the noise are the only inhabitants of the field. —Edmund Burke

Loneliness is a defeat, but solitude is a triumph, for it opens the gate toward a mature character and social responsibility. —Samuel Terrien

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NEW INSURANCE PROGRAM BEGINS

After careful study of available insurance plans, the Members' Insurance Committee has recommended a new program of Disability Income and Major Medical Expense Insurance as underwritten by the Commercial Insurance Company and administered by the Lester L. Burdick, Inc. This program was approved by the Executive Committee and will go into effect on January 15, 1967, replacing our previous insurance program.

Last spring, when the Committee was informed that the Hartford Accident and Indemnity Insurance Company was raising premiums by 30%, the Committee immediately began a study to determine whether or not this rate increase was justified, and whether it would be advantageous to remain under the present program or to institute a new one. Because of the time factor, members were advised at that time to pay the increased premium due on July 15, 1966, with the expectation that a decision would be made well in advance of the next premium date of January 15, 1967.

During the summer months, the Committee reviewed a number of insurance programs and arrived at the conclusion that the program underwritten by the Commercial Insurance Co. would be to the greatest advantage of all our members. Accordingly, the Hartford Accident and Indemnity Program is to be dropped. A charter enrollment period to install the new program is now in progress and will continue until January 15, 1967. All members are urged to enroll during this charter enrollment period. We have been assured that all members and eligible dependents currently insured

by the Hartford Accident and Indemnity Company will be guaranteed issuance of the replacement policy, regardless of past medical history, provided (1) that enrollment and payment of the initial premium is submitted to the Lester L. Burdick Company prior to Jan. 15, 1967; (2) that members are under 70 years of age and practicing on a full time basis (a wife must also be under age 70 years, and dependent unmarried children must be between the ages of 3 months and 21 years or 25 years if a full time student); (3) that they are not at present receiving benefits for disability. Members will continue to receive their benefits for disability arising prior to January 15, 1967, from the Hartford Accident and Indemnity Company. Upon recovery from their disability and upon their return to active full time practice, they will be insured under the new program if they submit their enrollment application within 60 days.

The Committee is of the opinion that this new program is definitely to our advantage and members are urged to discuss their own situations with the local representatives of the new administrator.

The Committee was dismayed to learn that the Lessere-Wertheim, Inc., administrators for the Hartford Accident and Indemnity Insurance Co., has already sent out premium notices on the old insurance program. Members are cautioned *not to pay this bill* since the new program, as administered by the Lessere L. Burdick, Inc., is replacing it.

H. Bernard Tillman, M.D.
Chairman,
Member's Insurance Committee

New Disability Income
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Officially Approved November 15, 1966

By The
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WHITE CAP BALL

The candles glowed and the gowns glittered as the Woman's Auxiliary to the HDMS held its fourteenth annual "White Cap Ball" Saturday night, November 5, 1966 at the Twin Hills Country Club, Longmeadow, Mass. More than 270 persons attended this sparkling event which featured an excellent dinner and carefree dancing to the music of Bernie Cohen's orchestra.

As usual the proceeds of this gala affair, which amounted to \$2,080.00, will go far in providing scholarships to qualified, needy students in Hampden County wishing to further or begin their studies in nursing or other allied medical fields of endeavor.

Mrs. Irving Hoff served as general chairman with Mrs. Sante Caldarola as co-chairman. Mrs. Eugene Beauchamp, Jr., President of the Auxiliary, served as honorary chairman. Other committee chairmen and members were:

- Invitations - Mrs. Joseph Greenspan
- Reservations - Mrs. Richard V. Paul and
Mrs. John Griffin
- Hostesses - Mrs. Setrag Zacarian
Mrs. Martin Poppo

- Mrs. Frank Sterba
- Mrs. John Zadworny
- Mrs. Richard Bye
- Mrs. Jack Pincus
- Mrs. William Sheehan

- Publicity - Mrs. Robert O'Malley
Mrs. Raymond Conway
Mrs. Harry Anton
Mrs. Walter Mozden

General Committee -

- Mrs. Aaron Burkin
- Mrs. Stanley Dixon
- Mrs. Arthur Gramse
- Mrs. Silvano Macchiaroli
- Mrs. Robert Mandell
- Mrs. Roger Parenteau
- Mrs. William Sheehan
- Mrs. Richard Lavin
- Mrs. Leandre Giguere

Scholarship - Mrs. William Mosig

Whole hearted thanks are hereby extended to all who helped make this edition of the "White Cap Ball" a joy to be long remembered. The candles have gone out and the glitter has faded away but only to await the next year.

- Mrs. Jean P. Aucoin
- Publicity to The Hippocrat



THE MEDICAL CREDITS DIVISION

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CARDIOLOGY GRAND ROUNDS

Beginning early in January of 1967, the Western Chapter of the Mass. Heart Association is sponsoring a series of Grand Rounds in cardiology. Physicians of Hampden, Hampshire, and Franklin counties are cordially invited to participate in this program. The following physicians, as arranged through the Postgraduate Medical Institute, will be the guest leaders:

January 7	Noble Hospital	Modestino G. Criscitiello, M.D. New England Medical Center, Boston
January 14	Mercy Hospital	Burton Polansky, M.D. Boston City Hospital Boston
January 21	Springfield Hospital	Paul Zoll, M.D. Beth Israel Hospital, Boston
January 28	Franklin County Hospital	William Elliott, M.D. Veterans Administration Hospital West Roxbury, Mass.
February 4	Cooley Dickinson Hospital	Alla G. Zaver, M.D. Lemuel Shattuck Hospital, Boston
February 11	Providence Hospital	Allan Goldblatt, M.D. Mass. General Hospital, Boston
February 25	Wing Memorial Hospital	David Spodick, M.D. Lemuel Shattuck Hospital, Boston
March 4	Noble Hospital	Roman W. DeSanctis, M.D. Mass. General Hospital, Boston
April 1	Cooley Dickinson Hospital	Joseph Messer, M.D. Boston City Hospital, Boston
April 8	Wing Memorial Hospital	William Hollander, M.D. University Hospital, Boston

MEMO :

The recently **revised edition** of the "Relative Value Study for HDMS" is now available at the Society's headquarters.

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HAMPDEN CAPSULES

Dr. Hayes attended the Clinical Conference of the AMA in Las Vegas as a member of the House of Delegates.

Dr. Allen Johnson, Alternate Delegate, also attended the Clinical Conference.

Speaking

Dr. Sheldon Goldberg to Memorial Society on Temporal Bone Banks.

Dr. Whitney to Future Nurses Club at Classical High School.

Dr. Teitel to Church of Good Shepherd on "Human Growth".

Dr. Zadworny to Jaycee-ettes showing "Human Growth".

"Quarter Million Teenagers" shown to the Mercy Hospital Nurses.

Drs. Zadworny and Twible speaking in Ashburnham with films "Human Growth" and "Quarter Million Teenagers".

Committee Meetings held during November:

Mental Health, Members' Insurance, Public Health, Executive.

December Meetings:

Censor, District Meeting, Public Health, Executive.



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SEASON'S GREETINGS

SPORTS INJURY PROGRAM

As part of an increasing attempt to inform coaches, trainers, physical education instructors, officials, and the public of advances made in the prevention and treatment of sports injuries, the second annual sports injury program as sponsored by the HDMS was held at the Springfield Municipal Hospital's auditorium on the afternoon of November 30, 1966. Proper equipment, sound physical conditioning, good health habits, and the proper mental attitude were cited as the best means of avoiding injury during participation in all types of sports.

Dr. Irving Meyer, strongly advocated the routine use of a proper face mask in football as well as a mouthpiece in all contact sports to prevent injury to teeth and fractures of facial bones, particularly, the jaw. Dr. Howard Crawford, discussed a variety of possible injuries to the spine and contiguous organs. Dislocations and fractures, some of which might go undetected, could be quite serious. A point was made that many physicians in the field are advocating routine back x-rays for athletes irrespective of any history of injury. Dr. Mordecai Berkowitz discussed injuries to the knees and ankles, which appear to be most vulnerable areas insofar as extremities are concerned. Emphasized also were bone "growth center" injuries in the young which could lead to impairment of future growth and de-

velopment of the respective bones involved.

It was generally agreed that major progress is being made in the development of protective equipment, but a healthy, well conditioned athlete is still a prime requisite, and even this is no guarantee. Persons participating in sports "must be willing to accept the chance of injury."

Ayres

THE SPRINGFIELD HOSPITAL EDUCATIONAL PROGRAM

Lester F. Soyka, M.D., Instructor in Pediatrics, Harvard Medical School, and Assistant in Pediatrics, Children's Service, Mass. General Hospital, Boston, will be the pediatric guest speaker on Thursday, January 5, 1967. His topic is entitled "Short Stature in Childhood — Diagnosis and Treatment." A clinical session will be held at 5:00 P.M.; pediatric rounds at 6:00 P.M., and the formal presentation at 8:00 P.M.

Nicholas M. Greene, M.D., Professor of Anesthesiology, Lecturer in Pharmacology, Yale University School of Medicine, and Director of Anesthesiology, Yale - New Haven Hospital, New Haven, Conn. will speak on "Anesthesia for Emergency Surgery" on Friday, January 20, 1967 at 7:30 P.M. in the Hospital's Auditorium.

All physicians, residents, interns, nurses and military personnel are cordially invited to attend.

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ACADEMY

The next meeting of the
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TUESDAY, JANUARY 10, 8:30 P.M.

- SPEAKER:** EDWARD KASS, M.D.
Director of Channing Laboratory
Boston City Hospital
Boston, Mass.
- TOPIC:** "PATHOGENESIS OF CHRONIC
BACTERIAL INFECTIONS"
- PLACE:** Auditorium, Municipal Hospital
Springfield
- HOSPITAL CLINIC:** Wesson Memorial Hospital, 5:00 P.M.

VISITING DIGNITARY

Dr. Milford O. Rouse, President-Elect of the AMA, will be visiting in Springfield on Friday, Jan. 13, 1967, and will be the guest speaker at the Rotary Club at the latter's regular meeting.

Dr. Rouse was chosen as President-Elect in June of 1966. Prior to this he had been Speaker of the House of Delegates since 1963 and Vice-Speaker for four years previously.

Dr. Rouse hails from Dallas, Texas, where he practices gastroenterology.

QUOTE OF NOTE

Goals become confused when people are confronted with too many trivial and unnecessary changes. People can tolerate only so much change and if they are bombarded with irritating small changes, they will be less likely to accept major ones.—Harwood F. Merrill, writing in Management News, April 1966.

If it is newsworthy and medical, the Hippocrat would like to hear about it.

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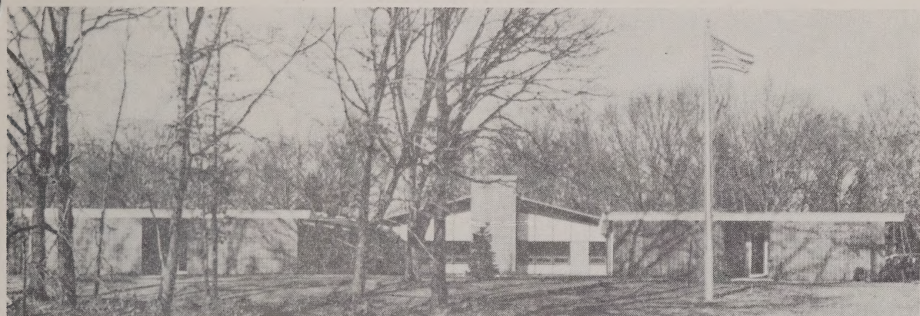
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